Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP LLC
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-0820-01

MFDR Date Received
November 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration letter: "We disagree with your payment for the fact that it was not paid based on correct locality 18. Claim was paid at the wrong locality 99 and should have paid at locality 18. We have contacted CMS in regard to the Zip Code issue and the payment on our claims. It appears that the carrier is utilizing the 5 digit zip code directory instead of the 9 digit file. The 4 digit extension is required in order to delineate the boundaries for Harris County (Locality 18) and other (locality 99). Our Katy office lies in Harris County."

Amount in Dispute: $19.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In support of its contention the requestor offers nothing tangible for evidentiary. He alludes to contact with CMS regarding this issue but nothing more. He argues Texas Mutual appears to have been paying based on locality 99, i.e. the rest of Texas, versus 18, Houston-Harris County, but offers no explanation as to how he arrived at this. In short the requestor offers conjecture."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2012, March 19, 2012 and April 9, 2012	99203, 20610 and 73560	$19.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1 – Workers compensation state fee schedule adjustment
   - CAC-193 – Original payment decision is being maintained. Upon review. It was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did the insurance carrier issue the correct fee guideline amount based on the information contained in box 32 of the CMS-1500?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - Review of the CMS MLN Matters® Number: MM7631 states in pertinent part, "The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable 'locality' and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS."
   - The zip code indicated in box 32 helps identify the applicable locality to arrive at the MPFS. The CMS-1500 documents in box "32. Service Facility Location Information" the following: "Fondren Orthopedic GP LLP, 23920 Katy Freeway, #400 Houston Texas 77494-1341." The requestor seeks additional reimbursement for disputed CPT codes 99203, 20610 and 73560 requesting payment for services rendered in "Houston locality". Refer to box 32 of the CMS-1500.
2. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. . ." Review of the submitted documentation finds that:
   - Review of box 32 of the CMS-1500 indicates that the requestor rendered the services in zip code 77494 identified by Medicare as "Rest of Texas." Although the requestor indicates that the services were rendered in Houston, Texas, the zip code identifies the place of service as Katy, Texas.
   - The insurance carrier issued reimbursement for zip code 77494 "Rest of Texas" identified in box 32 of the CMS-1500 in accordance with the provisions of 28 Texas Administrative Code §134.203 (c). The following payments were made to the requestor; $160.66 for CPT code 99203; $105.70 for CPT code 20610 and $47.63 for CPT code 73560.
   - The division finds that the insurance carrier issued the proper payment for services rendered in "Rest of Texas"; as a result, the requestor is not entitled to additional payment for the disputed charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 6, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.